FINAL RECOMMENDATION ON CASE MIX ADJUSTMENTS FOR FY 2008

Health Services Cost Review Commission
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This document is a revision of the final staff recommendation to the Commission at the March 5, 2008 public meeting

Background

The Fiscal Year 2008 rate agreement allows for case mix growth of up to 1.0 percent. The 1.0 percent allowance for case mix is inclusive of two components.

> Pass through amounts (sometimes called Level II and III case mix) these consist of trim payments (high and low outlier cases) and categorical exclusions (chronic care, organ acquisition, clinical trials, etc). These pass through amounts are excluded from the calculation of hospitals charge per case (CPC). For Fiscal Year 2008 staff anticipates that pass through amounts will grow by 0.20 percent.
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> Case mix growth (sometimes called Level I) this is the change in a hospital overall case mix as measured using the APR-DRG grouper, and reflects either the increased or decreased resource need of the patient population of a hospital.

During FY2006 and FY2007, as part of the payment system transition to APR-DRGs, the Commission applied a methodology that limited the amount of case mix growth that hospitals could realize. The approach, known as the governor, was imposed because case mix growth under APR-DRGs was anticipated to be high relative to historical standards as hospitals improved the completeness and depth of diagnosis coding on the discharge abstract. The governor took a graduated approach, with less credit is given to higher increments of case mix growth than lower increments. In addition to the governor, additional adjustments were made to final case-mix allowances to give greater weight to case mix changes caused by shifts among DRGs (root growth) than within DRGs (severity growth).

These adjustments were necessary during the transition to the APR-DRGs, but are no longer appropriate. The final recommendation for case mix for FY2007 of October 5, 2007 stated "root DRG adjustment recommended for FY2007 will not be appropriate in future years. The adjustment for root DRG change was meant to be a temporary response to a specific problem (increased depth of coding), and not a permanent aspect of the rate setting system. In coming years, case mix as measured by the APR-DRG system should adequately account for program and severity changes without additional adjustments."

At present, hospitals have submitted two quarters for FY2008 discharge data (one quarter final and one quarter preliminary). A comparison of case mix for these two quarters with the first two quarters of FY2007 indicates that case mix is currently growing at a rate of 0.3 percent. Based on these preliminary data, therefore, I t is likely that total measured case mix change for FY2008 will fall below 1.0 percent

The low rate of growth in measured case mix compared to the past two years indicates that case mix change resulting from increased documentation in response to the introduction of APR-DRGs has largely occurred. Case mix, therefore, is measuring changes in relative resource need caused by the severity of the patient population, and not coding changes.

As the table shows, the percentage of discharges coded to the 15th diagnosis no longer show the rapid growth of the earlier periods.

Table 1: Percent of Discharges Reporting 1 5 Diagnoses					
FY03	FY04	FY05	FY06	FY07	FY08 (6 months)
5.6%	7.2%	12.5%	18.0%	20.8%	22.3%

DISTRIBUTION OF CASE MIS CHANGE IN FY08

Consistent with its October 2007 recommendation, staff recommends that for FY2008 the distribution of case mix growth will be handled as follows:

Measured case mix change (inclusive of pass throughs and case mix) is 1.0 percent or less. Under this scenario hospitals will have their rates adjusted according to changes in measured case mix with no adjustments. Since preliminary estimates indicate that case mix growth will be less than 1.0 percent for FY08, the lower than anticipated growth will allow the Commission flexibility in other areas. Specifically:

- **No spend-downs as a result of the April reasonableness of charges (ROC) analysis.** The April ICC/ROC recommendation calls for allowing hospitals eligible to apply for a full rate review to do so. It also states that while, under the current methodology, a large number of hospitals would be subject to spend-downs, no spend-downs be implemented until the ROC methodology undergoes additional refinement in the fall.
- **Improvement against the Medicare Waiver.** The lower than anticipated growth in case mix will improve Maryland's position against it CMS waiver test. Relative savings due to lower case mix growth are preferable to across the board cuts, as they more accurately reflect a hospital resource use.

Measured case mix change (inclusive of pass throughs and case mix) is greater than 1.0 percent. Under this scenario, hospitals experiencing positive case mix shall receive case mix growth proportionate to revenue such that total case mix growth shall be 1.0 percent. In addition, an adjustment will be made for hospitals that experience negative case mix growth followed by positive case mix growth (the "Downs and Ups"). The governor methodologies that were previously applied can disadvantage hospitals that experience negative case mix growth followed by positive growth, as the negative growth was ungoverned (i.e. the full amount of the decline is accounted for in the hospital CPC) while the subsequent growth is limited by the governor. Thus a hospital that may be experiencing some real cyclical variation in case mix can lose revenue inappropriately. Consistent with the policy applied case mix changes in FY2007, staff recommends that hospitals that experience a case mix decline in FY2007 be allowed case mix growth subject to no adjustment for the amount of that decline in FY2008. For example, a hospital had -0.5 percent case mix growth in FY06 followed by positive measured case mix growth of 1.5 percent in FY07 the first 0.5 percent of case mix growth would not be subject to any proportionate adjustment.

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Sent via e-mail. Hard copy to follow.

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Re: 2008 Case-Mix Measurement

Dear John:

On behalf of the 68 members of The Maryland Hospital Association (MHA), I appreciate the opportunity to comment on the HSCRC Staff Draft Recommendation on Case-Mix Adjustments. We agree with the underlying premise of the recommendation: Maryland hospitals have completed or nearly completed the transition to APR DRGs and case-mix as measured by the APR grouper reflects case-related resource use in Maryland hospitals. Accordingly, we support proportionate sharing of the 1.0 percent budgeted for 2008, both retro and prospective. But we further recommend that since the transition to APR DRGs is complete, and case-mix measured under the APR grouper represents real change, any proportionate sharing in allowed case-mix growth should apply symmetrically to case-mix declines.

But, we would like to take this opportunity to again urge the commission to make policy and methodology changes in advance of the rate year in which those changes become effective. Predictability is a hallmark on which the Maryland payment system was designed. Without final methodology decisions, it is difficult for hospitals to monitor and predict revenue accurately and to manage budgeting and planning processes.

We are also concerned that the staff's proposal says that if actual case-mix growth is less than 1.0 percent, only the calculated amount will be distributed. The 1.0 percent budget was part of the overall revenues approved for the industry as part of the FY 2008 negotiation. The entire amount should be distributed.

As always, we appreciate the opportunity to comment on your proposed methodology. If I can answer any questions or provide additional information, please contact me. I look forward to continuing to work with you on this and related issues.

Sincerely,

Robert Z. Vovak
Senior Vice President & CFO

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